DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 8

2. STATE: Montana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Title 42

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 02,800
b. FFY 2002 $ 0# 11,437.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 1 and 2 of attachment 4.19B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 1 and 2 of attachment 4.19B

10. SUBJECT OF AMENDMENT:
Durable Medical Equipment

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Gray

13. TYPED NAME:
Gail Gray

14. TITLE:
Director

15. DATE SUBMITTED:
08/30/01

16. RETURN TO:
Gail Gray
Department of Public Health & Human Services
PO Box 202951
Helena MT 59620-2951

Attn: Jean Robertson 406-444-9524

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 31, 2001

18. DATE APPROVED:
10/18/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

MONTANA

I. Reimbursement for Durable Medical Equipment and Supplies shall not exceed the lower of:

A. The provider's Usual and Customary Charge ("UCC") amount submitted on the claim to Medicaid.

B. The Department's fee schedule as follows:

1. Specified fees for:

Durable Medical Equipment and supplies for which there is not a statistically significant volume* or which includes variable modifications. These are reimbursed at 90% of UCC.

2. Wheelchairs and accessories will be reimbursed at 80% of UCC.

3. Rental items listed as "capped" rental under Medicaid are limited to 12 months rental. Rental for items needing frequent servicing as classified by Medicare can be rented as long as the medical necessity exists. Other rentals are limited to Medicaid purchase fee, or if no fee exists, the suppliers' purchase price as long as it is reasonable.

(a) . rental fees include all necessary supplies needed to operate rented equipment for the month.

*A statistically significant volume of service is a number of services billed to the Medicaid program during a calendar year which will provide sufficient data for calculating a reasonable prevailing charge, using the Medicaid methods.

II. Reimbursement for home infusion therapy shall not exceed the lowest of:

A. The provider's usual and customary charge of the therapy to the general public; or

B. The Medicaid fee established as a daily rate for home infusion therapy providers.

Daily rates for various therapies were established based on the usual and customary charges reported by home infusion therapy providers in the State of Montana. The daily rate for each therapy was derived by averaging the individual provider charges. The Department worked with providers to reach agreement on reimbursement for individuals' infusion therapies.